

CHAPTER 13  
STANDARDS OF PRACTICE AND PROFESSIONAL ETHICS

[Prior to 5/4/88, see 470—135.251 to 470—135.402]

**653—13.1(148,272C) Standards of practice—packaging, labeling and records of prescription drugs dispensed by a physician.**

**13.1(1)** A physician shall dispense a prescription drug only in a container which meets the requirements of the Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471-1476 (2001), unless otherwise requested by the patient, and of Section 502G of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. ss. 301 et seq. (2001).

**13.1(2)** A label shall be affixed to a container in which a prescription drug is dispensed by a physician which shall include:

1. The name and address of the physician.
2. The name of the patient.
3. The date dispensed.
4. The directions for administering the prescription drug and any cautionary statement deemed appropriate by the physician.
5. The name and strength of the prescription drug in the container.

**13.1(3)** The provisions of subrules 13.1(1) and 13.1(2) shall not apply to packaged drug samples.

**13.1(4)** A physician shall keep a record of all prescription drugs dispensed by the physician to a patient which shall contain the information required by subrule 13.1(2) to be included on the label. Noting such information on the patient's chart or record maintained by the physician is sufficient.

This rule is intended to implement Iowa Code sections 147.55, 148.6, 272C.3 and 272C.4.

**653—13.2(148,150,150A,272C) Standards of practice—prescribing or administering controlled substances for the treatment of patients with chronic, nonmalignant pain.** This rule establishes standards of practice for the management of chronic, nonmalignant pain. The purpose of the rule is to assist physicians who prescribe and administer drugs to provide relief and eliminate suffering in patients with chronic, nonmalignant pain as defined in this rule.

**13.2(1) Definitions.** As used in this rule:

*“Agency for Healthcare Research and Quality”* or *“AHRQ”* means the agency within the U.S. Department of Health and Human Services which is responsible for establishing Clinical Practice Guidelines on various aspects of medical practice.

*“American Academy of Pain Medicine”* or *“AAPM”* means the American Medical Association-recognized specialty society of physicians who practice pain medicine in the United States. The mission of the AAPM is to enhance pain medicine practice by promoting a climate conducive to the effective and efficient practice of pain medicine.

*“American Pain Society”* or *“APS”* means the national chapter of the International Association for the Study of Pain, an organization composed of physicians, nurses, psychologists, scientists and other professionals who have an interest in the study and treatment of pain. The mission of the APS is to serve people in pain by advancing research, education, treatment and professional practice.

*“Chronic, nonmalignant pain (i.e., not caused by cancer)”* means persistent or episodic pain of a duration or intensity that adversely affects the functioning or well-being of a patient when (1) no relief or cure for the cause of pain is possible; (2) no relief or cure for the cause of pain has been found; or (3) relief or cure for the cause of pain through other medical procedures would adversely affect the well-being of the patient.

**13.2(2) General provisions.** Various controlled drugs, particularly opioid analgesics, can be safely and effectively utilized to control pain in certain patients. However, inappropriate prescribing of controlled substances can lead to, or accelerate, drug abuse and diversion. Therefore, the medical management of pain shall be based on a thorough knowledge of pain assessment, pain treatment, and concern for the patient.

*a. Treatment of acute pain and cancer pain.* Physicians may refer to the Clinical Practice Guidelines published by the AHRQ for counsel on the proper treatment of acute pain and chronic pain associated with cancer. The AHRQ Clinical Practice Guidelines provide a sound, compassionate, and flexible approach to the management of pain in these patients.

*b. Treatment of chronic, nonmalignant pain.* The basic premise underlying this rule is that various drugs, particularly opioid analgesics, may be useful for treating patients with chronic, nonmalignant pain in a safe, effective, and efficient manner when other efforts, including those by other practitioners or the patient, have failed to remove or effectively treat the pain. The board strongly recommends that physicians who have reservations about the use of drugs in the treatment of chronic, nonmalignant pain consult: Definitions Related to the Use of Opioids for the Treatment of Pain, a consensus document from the American Academy of Pain Medicine (AAPM), the American Pain Society (APS), and the American Society of Addiction Medicine (ASAM) (2001). Copies of the document are available from the AAPM (<http://www.painmed.org>), the APS (<http://www.ampainsoc.org>), the ASAM (<http://www.asam.org>), and the office of the board at 400 S.W. 8th Street, Suite C, Des Moines, Iowa 50309-4686.

**13.2(3) Effective chronic, nonmalignant pain management.** To ensure that pain is properly and promptly assessed and treated, a physician who prescribes or administers controlled substances to a patient for the treatment of chronic, nonmalignant pain shall exercise sound clinical judgment by establishing an effective pain management plan in accordance with the following:

*a. Patient evaluation.* A patient evaluation that includes a physical examination and a comprehensive medical history shall be conducted prior to the initiation of treatment. The evaluation shall also include an assessment of the pain, physical and psychological function, diagnostic studies, previous interventions, including medication history, substance abuse history and any underlying or coexisting conditions. Consultation/referral to a physician with expertise in pain medicine, addiction medicine or substance abuse counseling or a physician who specializes in the treatment of the area, system, or organ perceived to be the source of the pain may be warranted depending upon the expertise of the physician and the complexity of the presenting patient. Interdisciplinary evaluation is strongly encouraged.

*b. Treatment plan.* The physician shall establish a comprehensive treatment plan that tailors drug therapy to the individual needs of the patient. To ensure proper evaluation of the success of the treatment, the plan shall clearly state the objectives of the treatment, for example, pain relief, or improved physical or psychosocial functioning. The treatment plan shall also indicate if any further diagnostic evaluations or treatments are planned and their purposes. The treatment plan shall also identify any other treatment modalities and rehabilitation programs utilized.

*c. Informed consent.* The physician shall document discussion of the risks and benefits of controlled substances with the patient or person representing the patient.

*d. Periodic review.* The physician shall periodically review the course of drug treatment of the patient and the etiology of the pain. Modification or continuation of drug therapy by the physician shall be dependent upon evaluation of the patient's progress toward the objectives established in the treatment plan. The physician shall consider the appropriateness of continuing drug therapy and the use of other treatment modalities if periodic reviews indicate the objectives of the treatment plan are not being met or there is evidence of diversion or a pattern of substance abuse.

*e. Consultation/referral.* The physician shall consider consultation with, or referral to, a physician with expertise in pain medicine, addiction medicine or substance abuse counseling, if the objectives of the treatment plan are not being met or there is evidence of diversion or a pattern of substance abuse.

*f. Documentation.* The physician shall keep accurate, timely, and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient's condition and treatment.

*g. Physician-patient agreements.* Physicians treating patients at risk for substance abuse shall consider establishing physician-patient agreements that specify the rules for medication use and the consequences for misuse. In preparing agreements, a physician shall evaluate the case of each patient on its own merits, taking into account the nature of the risks to the patient and the potential benefits of treatment.

*h. Termination of care.* The physician shall consider termination of patient care if there is evidence of diversion or a repeated pattern of substance abuse.

**653—13.3(147) Supervision of pharmacists who administer adult immunizations.** A physician may prescribe adult immunizations via written protocol for influenza and pneumococcal vaccines for administration by an authorized pharmacist if the physician meets these requirements for supervising the pharmacist.

**13.3(1) Definitions.**

*a. "Authorized pharmacist"* means an Iowa-licensed pharmacist who has documented that the pharmacist has successfully completed an educational program meeting the training standards on vaccine administration as provided by an American Council on Pharmaceutical Education (ACPE)-approved provider of continuing pharmaceutical education that:

(1) Requires documentation by the pharmacist of current certification in the American Heart Association or the Red Cross Basic Cardiac Life Support Protocol for health care providers;

(2) Is an evidence-based course that includes study material and hands-on training and techniques for administering vaccines, requires testing with a passing score, complies with current Centers for Disease Control and Prevention guidelines, and provides instruction and experiential training in the following content areas:

1. Standards for immunization practices;
2. Basic immunology and vaccine protection;
3. Vaccine-preventable diseases;
4. Recommended immunization schedules;
5. Vaccine storage and management;
6. Informed consent;
7. Physiology and techniques for vaccine administration;
8. Pre- and post-vaccine assessment and counseling;
9. Immunization record management; and
10. Management of adverse events, including identification, appropriate response, documentation, and reporting.

b. “Vaccine” means a specially prepared antigen which, upon administration to a person, will result in immunity and, specifically for the purposes of this rule, shall mean influenza and pneumococcal vaccines.

c. “Written protocol” means a physician’s order for one or more patients that contains, at a minimum, the following:

(1) A statement identifying the individual physician authorized to prescribe drugs and responsible for the delegation of administration of adult immunizations for influenza and pneumococcus;

(2) A statement identifying the individual authorized pharmacists;

(3) A statement that forbids an authorized pharmacist from delegating the administration of adult immunizations to anyone other than another authorized pharmacist or a registered nurse;

(4) A statement identifying the vaccines that may be administered by an authorized pharmacist, the dosages, and the route of administration;

(5) A statement identifying the activities an authorized pharmacist shall follow in the course of administering adult immunizations, including:

1. Procedures for determining if a patient is eligible to receive the vaccine;

2. Procedures for determining the appropriate scheduling and frequency of drug administration in accordance with applicable guidelines;

3. Procedures for record keeping and long-term record storage including batch or identification numbers;

4. Procedures to follow in case of life-threatening reactions; and

5. Procedures for the pharmacist and patient to follow in case of reactions following administration;

(6) A statement that describes how the authorized pharmacist shall report the administration of adult immunizations, within 30 days, to the physician issuing the written protocols and to the patient’s primary care physician, if one has been designated by the patient. In case of serious complications, the authorized pharmacist shall notify the physicians within 24 hours and submit a VAERS report to the bureau of immunizations, Iowa department of public health. (VAERS is the Vaccine Advisory Event Reporting System.) A serious complication is one that requires further medical or therapeutic intervention to effectively protect the patient from further risk, morbidity, or mortality.

**13.3(2) Supervision.** A physician who prescribes adult immunizations to an authorized pharmacist for administration shall adequately supervise that pharmacist. Physician supervision shall be considered adequate if the delegating physician:

a. Ensures that the authorized pharmacist is prepared as described in subrule 13.3(1), paragraph “a”;

b. Provides a written protocol that is updated at least annually;

c. Is available through direct telecommunication for consultation, assistance, and direction, or provides physician backup to provide these services when the physician supervisor is not available;

d. Is an Iowa-licensed physician who has a working relationship with an authorized pharmacist within the physician’s local provider service area.

**13.3(3) Administration of other adult immunizations by pharmacists.** A physician may prescribe, for an individual patient by prescription or medication order, other adult immunizations to be administered by an authorized pharmacist.

This rule is intended to implement Iowa Code sections 147.76 and 272C.3.

**653—13.4(147,148,150) Standards of practice—chelation therapy.** Chelation therapy or disodium ethylene diamine tetra acetic acid (EDTA) may only be used for the treatment of heavy metal poisoning or in the clinical setting when a licensee experienced in clinical investigations conducts a carefully controlled clinical investigation of its effectiveness in treating other diseases or medical conditions under a research protocol that has been approved by an institutional review board of the University of Iowa or Des Moines University—Osteopathic Medical Center.

This rule is intended to implement Iowa Code chapters 147, 148, and 150.

**653—13.5** Reserved.

**653—13.6(79GA, HF726) Standards of practice—automated dispensing systems.** A physician who dispenses prescription drugs via an automated dispensing system or a dispensing system that employs technology may delegate nonjudgmental dispensing functions to staff assistants in the absence of a pharmacist or physician provided that the physician utilizes an internal quality control assurance plan that ensures that the medication dispensed is the medication that was prescribed. The physician shall be physically present to determine the accuracy and completeness of any medication that is reconstituted prior to dispensing.

**13.6(1)** An internal quality control assurance plan shall include the following elements:

- a. The name of the physician responsible for the internal quality assurance plan and testing;
- b. Methods that the dispensing system employs, e.g., bar coding, to ensure the accuracy of the patient's name and medication, dosage, directions and amount of medication prescribed;
- c. Standards that the physician expects to be met to ensure the accuracy of the dispensing system and the training and qualifications of staff members assigned to dispense via the dispensing system;
- d. The procedures utilized to ensure that the physician(s) dispensing via the automated system provide(s) patients counseling regarding the prescription drugs being dispensed;
- e. Staff training and qualifications for dispensing via the dispensing system;
- f. A list of staff members who meet the qualifications and who are assigned to dispense via the dispensing system;
- g. A plan for testing the dispensing system and each staff member assigned to dispense via the dispensing system;
- h. The results of testing that show compliance with the standards prior to implementation of the dispensing system and prior to approval of each staff member to dispense via the dispensing system;
- i. A plan for interval testing of the accuracy of dispensing, at least annually; and
- j. A plan for addressing inaccuracies, including discontinuing dispensing until the accuracy level can be reattained.

**13.6(2)** Those dispensing systems already in place shall show evidence of a plan and testing within two months of August 31, 2001.

**13.6(3)** The internal quality control assurance plan shall be submitted to the board of medical examiners upon request.

This rule is intended to implement Iowa Code section 147.107 and 2001 Iowa Acts, House File 726, section 5(10), paragraph "i."

**653—13.7 to 13.9** Reserved.

## PROFESSIONAL ETHICS

**653—13.10(147,148,272C) Principles of medical ethics.** The following principles of medical ethics prepared and approved by the judicial council of the American Medical Association, which are set out in a 1977 publication entitled "Opinions and Reports of the Judicial Council," published by the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 61610, are hereby adopted by the board relative to the practice of medicine and surgery in this state:

**13.10(1)** These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of conduct in relationship with patients, with colleagues, with members of allied professions, and with the public.

**13.10(2)** The principal objective of the medical profession is to render service to humanity with full respect for dignity. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

**13.10(3)** Physicians should strive continually to improve medical knowledge and skill and should make available to their patients and colleagues the benefits of their professional attainments.

**13.10(4)** A physician should practice a method of healing founded on a scientific basis; and the physician should not voluntarily associate professionally with anyone who violates this principle.

**13.10(5)** The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

**13.10(6)** A physician may choose whom they will serve. In an emergency, however, the physician should render service to the best of their ability. Having undertaken the case of a patient, the physician may not neglect the patient; and unless the patient has been discharged they may discontinue their services only after giving adequate notice. The physician should not solicit patients.

**13.10(7)** A physician should not dispose of their services under terms or conditions which tend to interfere with or impair the free and complete exercise of their medical judgment and skill or tend to cause a deterioration of the quality of medical care.

**13.10(8)** In the practice of medicine a physician should limit the source of their professional income to medical services actually rendered by them, or under their supervision to their patients. The physician's fee should be commensurate with the services rendered and the patient's ability to pay. The physician should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient.

**13.10(9)** A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

**13.10(10)** A physician may not reveal the confidences entrusted to them in the course of medical attendance, or the deficiencies they may observe in the character of patients, unless they are required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

**13.10(11)** The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve the physician's interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community.

**653—13.11(147,148,272C) Code of ethics of osteopathic profession.** The following code of ethics published and approved by the American Osteopathic Association and published in a book entitled "1977 American Osteopathic Association Year Book and Director of Osteopathic Physicians," is hereby adopted by the board relative to the practice of osteopathic medicine and surgery or osteopathy in this state:

**13.11(1)** The physician shall keep in confidence whatever they may learn about a patient in the discharge of professional duties. Information shall be divulged by the physician when required by law or when authorized by the patient.

**13.11(2)** The physician shall give a candid account of the patient's condition to the patient or to those responsible for the patient's care.

**13.11(3)** A physician-patient relationship must be founded on mutual trust, cooperation, and respect. The patient, therefore, must have complete freedom to choose their physician. The physician must have complete freedom to choose patients whom they will serve. In emergencies, a physician should make their services available.

**13.11(4)** The physician shall give due notice to the patient or to those responsible for the patient's care when the physician withdraws from a case so that another physician may be summoned.

**13.11(5)** A physician is never justified in abandoning a patient.

**13.11(6)** A physician shall practice in accordance with the body of systematized knowledge related to the healing arts and shall avoid professional association with individuals or organizations which do not practice or conduct organization affairs in accordance with such knowledge.

**13.11(7)** A physician shall not be identified in any manner with testimonials for proprietary products or devices advertised or sold directly to the public.

**13.11(8)** A physician shall not hold forth or indicate possession of any degree recognized as the basis for licensure to practice the healing arts unless the physician is actually licensed on the basis of that degree in the state in which he practices.

**13.11(9)** A physician shall obtain consultation whenever requested to do so by the patient. A physician should not hesitate to seek consultation whenever the physician believes it advisable.

**13.11(10)** Illegal, unethical or incompetent conduct of physicians shall be revealed to the proper tribunals.

**13.11(11)** A physician shall not assume treatment of a patient under the care of another physician except in emergencies and only during the time that the attending physician is not available unless requested by the patient.

**13.11(12)** Any fee charged by a physician shall be reasonable.

**13.11(13)** A physician shall not pay or receive compensation for referral of patients.

**13.11(14)** The physician shall cooperate fully in complying with all laws and regulations pertaining to practice of the healing arts and protection of the public health.

Rules 13.10(147,148,272C) and 13.11(147,148,272C) are intended to implement Iowa Code sections 147.55 and 147.76.

**653—13.12(17A,147,148,272C) Waiver or variance prohibited.** Rules in this chapter are not subject to waiver or variance pursuant to IAC 653—Chapter 3 or any other provision of law.

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